DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2003-07**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.70 HIPAA

7. FEDERAL BUDGET IMPACT:
a. FFY **2004** **$ 375,000**
b. FFY **2005** **$ 450,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Exhibit 4.19-B, Exhibit "A", Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 9a, 9b & 9c
Exhibit 4.19-B, Exhibit "A", Pages 1a and 3a
Exhibit 4.19-B, Pages 7 & 7a
Exhibit 4.19-B, Exhibit "A", Pages 10-14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Exhibit 4.19-B, Exhibit "A" Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 9a, 9b & 9c
New
Attachment 4.19-B, Page 7
Delete these pages

10. SUBJECT OF AMENDMENT: This State Plan Amendment is being filed to allow the Division of Medicaid to change the medical supply payment methodology to include an add-on to the payment rates set for the Skilled Nursing Care, Physical Therapy, Speech Therapy, and Aide visits; this amendment also includes various technical corrections. The section pertaining to Durable Medical Equipment is being deleted from the Home Health Agency Reimbursement Plan (Attachment 4.19-B, Exhibit A, Pages 10-14) and transferred to the section of the Plan for Other Types of Care (Attachment 4.19-B, Pages 7 and 7a).

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Sharon Y. Reed for RLP

13. TYPED NAME: **Rica Lewis-Payton**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: **September 11, 2003**

16. RETURN TO:
Rica Lewis-Payton, Executive Director
Miss. Division of Medicaid
Attn: Rose Compere
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 11, 2003

18. DATE APPROVED:
March 3, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Renard Murray

21. TYPED NAME:
Renard Murray

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:
Approved with the attached corrections made to items 8, 9 and 10 (see attached sheet).
Changes were authorized by the State on e-mail dated 02/26/04 (corrected HCFA-179 which was not signed).

FORM HCFA-179 (07-92)

Item 8 changed to read:

Attachment 4.19-B, Exhibit "A", Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 9a, 9b & 9c	Attachment 4.19-B, Exhibit "A", Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 9a, 9b & 9c
Attachment 4.19-B, Exhibit "A", Pages 1a and 3a	New
Attachment 4.19-B, Exhibit "A", Pages 10 and 11	Changed from Pages 13-14
Attachment 4.19-B, Exhibit "A", Pages 12, 13 & 14	Delete these pages
Attachment 4.19-B, Page 7	Attachment 4.19-B, Page 7

Item 9 changed to read:

Item 10 changed to read:

This State Plan Amendment is being filed to allow the Division of Medicaid to change the medical supply payment methodology to include an add-on to the payment rates set for the Skilled Nursing Care, Physical Therapy, Speech Therapy, and Aide visits; this amendment also includes various technical corrections. The section pertaining to Grounds for Imposition of Sanctions (original pages 10-12) is being deleted and the section pertaining to DME/Medical Supplies is being moved from pages 13 and 14 to pages 10 and 11.

METHODS AND STANDARDS FOR ESTABLISHING RATES – OTHER TYPES OF CARE

Home Health Care Services- Payment for home health services shall be on the basis of cost or charges, whichever is less, as determined under standards and principles applicable to Title XVIII, not to exceed in cost the prevailing cost of skilled nursing home services under Medicaid. Effective July 1, 1981, payment for Home Health Services is in accordance with the Mississippi Title XIX Home Health Agency Reimbursement Plan (see Exhibit "A" pages 1-9c, attached); however, under no circumstances will the cost of Home Health Services exceed the cost of skilled nursing home services per month under the Medicaid Program.

Home Health care services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph and in Exhibit A of Attachment 4.19-B.

Durable Medical Equipment Services- Payment for Durable Medical Equipment (DME) is in accordance with the Mississippi Title XIX Durable Medical Equipment Reimbursement Plan at Exhibit "A", page 10.

Medical Supplies- Payment for medical supplies is in accordance with Mississippi Title XIX Medical Supply Reimbursement at Exhibit "A", page 11.

MISSISSIPPI TITLE XIX HOME HEALTH
AGENCIES REIMBURSEMENT PLAN

I. Cost Finding and Cost Reporting

A. Each home health agency participating in the Mississippi Medicaid Program will submit a uniform cost report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. There will be no extensions granted. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII, if applicable. One (1) completed copy of the cost report, with original signature, must be submitted to the Division of Medicaid (DOM).

B. Cost reports must be postmarked by the specified due date, unless a waiver is granted by the Executive Director of the Division of Medicaid, in order to avoid a penalty in the amount of $50.00 per day for each day the cost report is delinquent. Cost reports with a due date that falls on a weekend, a State of Mississippi holiday or a federal holiday will be due the following business day.

A home health agency which does not file a cost report within six (6) calendar months after the close of its cost reporting year may be subject to cancellation of its provider agreement at the discretion of the Division of Medicaid, Office of the Governor.

In order for cost reports to be considered complete, the following information must be filed:

1. Cost report with original signature (1 copy)
2. Working Trial Balance including assets and liabilities (1 copy)
3. Depreciation Schedule (1 copy)
4. Home office cost report and other Related Party support, i.e., a detailed statement of total costs with adjustments for non-allowable costs and a description of the basis used to allocate the costs, along with a narrative description or a copy of contracts of management services provided by the related party or home office (1 copy)
5. Medicaid Cost Reporting Schedules, i.e., Medicaid costs and visits by discipline and a schedule to reflect the lower of reasonable costs or customary charges as applicable to Medicaid (1 copy)
6. Medicare provider questionnaire and related Exhibits (1 copy)
7. Supporting workpapers for the Medicare cost report Worksheets for reclassifications, adjustments, and related party expenses (1 copy)

8. A narrative description of purchased management services or a copy of contracts for managed services (1 copy); and
9. Verification of the Medicare and Medicaid surety bond premiums included in the cost report (1 copy).

If all required information is not submitted with the original cost report on the due date, the provider will be notified via a faxed letter to the Administrator of the facility of the specific items missing and will be given 10 working days to submit the missing information. If the information has not been received by the 10th day, a second request letter will be faxed to the Administrator. The provider will have 5 working days to submit the information. Failure to submit the information postmarked no later than the due date of the second request, will result in the related costs being disallowed. The provider will not be allowed to submit the information at a later date, amend the cost report in order to submit the requested information, or appeal the desk review and/or audit as a result of the omission of the requested information.

C. All home health agencies are required to maintain financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical records. All records must be available upon demand to representatives, employees or contractors of the Division of Medicaid (DOM), Mississippi State Department of Audit, General Accounting Office (GAO) or the United States Department of Health & Human Services (HHS).

D. Records of related organizations as defined by 42 CFR 413.17 must be available upon demand to representatives, employees or contractors of the DOM, Auditor General, GAO, or HHS.

E. DOM shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60 and Mississippi State Law. Access to submitted cost reports will be in conformity with Mississippi Statutes. Upon request for a copy of any cost report, the home health agency involved will be notified as to why and what is being requested. Unless otherwise advised, the cost report will be released to the requestor 10 days from receipt of the request by the DOM or fiscal agent.

II. Audits

A. Background

Medicaid (Title XIX) requires that home health agencies be reimbursed on a reasonable cost related basis. Medicare (Title XVIII) is reimbursed based on a prospective payment system. To assure that payment of reasonable cost is being achieved, a comprehensive audit program has been established.

The common audit program has been established to reduce the cost of auditing submitted cost reports under the above programs and to avoid duplicate auditing efforts. The purpose then is to have one audit which will serve the needs of participating programs reimbursing home health agencies for services rendered.

B. Common Audit Program

The Division of Medicaid has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries shall provide the Division of Medicaid the results of desk reviews and field audits of those agencies, located in Mississippi.

C. Other Audits

For those home health agencies not covered by the common audits agreement with Medicare intermediaries, the Bureau of Compliance and Financial Review of the Division of Medicaid shall be responsible for performance of field reviews and field audits. The Bureau of Reimbursement of the Division of Medicaid will be responsible for performance of desk reviews.

D. Retention

All audit reports received from Medicare intermediaries or issued by the Division of Medicaid will be retained for a period of at least five (5) years.

E. Overpayment

Overpayments as determined by desk review or audit will be reimbursable to the Division of Medicaid. All overpayments shall be reported to HHS as required.

F. Desk Review Appeals

A provider may appeal the results of their original desk review. The appeal must be made in writing to the Division of Medicaid within thirty (30) calendar days of the date of the original desk review. The written request for appeal should include the provider=s name, provider number, cost reporting period, and a detailed description of the adjustment(s) being appealed. Workpapers and CFR references supporting the basis of the appeal should also be submitted.

If the appeal is submitted on a timely basis and includes all required information, the Division of Medicaid will review the appeal request and respond to the provider within sixty (60) calendar days of the date of receipt of all the required information. If the provider is not satisfied with the results of the appeal, within thirty (30) calendar days of the date of the Division of Medicaid=s original response to the appeal, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forthwith particularly the facts which the provider contends places him in compliance with the Division of Medicaid=s regulations or his defenses thereto.

Unless a timely and proper request for a hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination. The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the Division of Medicaid.

G. Final Cost Reports

The final cost reports received from Medicare intermediaries will be used as received from the intermediary to adjust rates. Providers may not appeal to the Division of Medicaid for the results of final cost reports. Appeals should be made to the Medicare intermediary under the procedures established by the intermediary. Once appealed adjustments have been resolved by the Medicare intermediary, the provider=s rates will be adjusted if necessary, based on the amended final cost report. (See Section III.I.7 and 8.)

III. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the Provider Reimbursement Manual (HIM-15) except as modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Mississippi Medicaid Program.

A. All items of expense may be included which home health agencies must incur in meeting:

1. The definition of a home health agency to meet the requirements of Section 1901(a)(13) of the Social Security Act.

2. Requirements established by the State Agency responsible for establishing and maintaining health standards.

3. Any other requirements for licensing under the State Law which are necessary for providing home health services.

B. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then the excess costs would not be reimbursable under the plan.

C. A proportion of costs incurred by a home health agency for services to an eligible Medicaid patient for whom payments are received from third parties are not reimbursable under this plan. Appropriate adjustments shall be made.

D. Cost reports for years ended within a calendar year will be used to establish the class ceilings and home health agency rates beginning the following October 1. For example, cost reports ended during 1996 will be used to compute the rate effective October 1, 1997. The exception will be the cost reports for periods ended in 1995. These cost reports will be used to compute the class ceilings and home health agency rates for a fifteen (15) month period. The 1995 cost reports will be used to compute rates for the period July 1, 1996 through September 30, 1997. This will allow for a transition from a rate year of July 1 through June 30 to a rate year of October 1 through September 30. If a provider experiences a change of ownership and files two cost reports during the calendar year, the last filed cost report will be used. Providers will be notified of their respective rates by type of visit and rate ceilings by type of visit prior to implementation of the rates. Any provider of home health services under the Medicaid Program may appeal its prospective rates in accordance with Section VI of this Plan.

E. The DOM shall maintain any responses received on the plan, subsequent changes to the plan, or rates for a period of five (5) years from the date of receipt. Such comments shall be available to the public upon request.

F. A home health agency may at times offer to the public new or expanded services or may drop a service. Within sixty (60) days after such an event, the home health agency may submit a budget which shall take into consideration new and expanded services or dropped services. Such budgets will be subject to desk review and audit by the DOM. Upon completion of the desk review, new reimbursement rates will be established. Failure to submit budgets within sixty (60) days shall require disallowance of all expenses, direct and indirect, associated with the service. Overpayments as a result of the differences between budget and actual costs shall be refunded to the DOM. New reimbursement rates shall not exceed the established class ceilings.

G. Type of visit ceilings and individual provider's reimbursement rates will not include amounts representing growth allowances.

H. Payment by type of visit and type of visit ceilings will be established prospectively.